
Financing Geriatric Programs In Community Health Centers

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Synopsis

There are approximately 600 Community and Migrant Health Centers (C/MHCs) providing preventive and primary health care services principally to medically underserved rural and urban areas across the United States. The need to develop geriatric programs within C/MHCs is clear. Less clear is how and under what circumstances a comprehensive geriatric program can be adequately financed.

THERE ARE APPROXIMATELY 600 Community and Migrant Health Centers (C/MHCs) across the United States providing preventive and primary health care services. These centers are generally located in medically underserved rural and urban areas, and typically they offer complete physical examinations, treat acute illness and infectious disease, monitor chronic impairments, and perform laboratory testing (1). C/MHCs obtain funding through annual grants under sections 329 and 330 of the Public Health Service Act, as well as from a variety of State and local sources, patient and third party reimbursement, and private and corporate grants and donations.

The need to develop geriatric programs within C/MHCs is clear (2,3). Currently, the elderly make up about 12 percent of the U.S. population, and by

The Health Resources and Services Administration of the Public Health Service contracted with La Jolla Management Corporation and Duke University Center on Aging to identify successful techniques for obtaining funding by examining 10 "good practice" C/MHC geriatric programs.

The results from this study indicated that effective techniques included using a variety of funding sources, maintaining accurate cost-per-user information, developing a marketing strategy and user incentives, collaborating with the area agency on aging and other community organizations, and developing special services for the elderly.

Developing cost-per-user information allowed for identifying appropriate "drawing card" services, negotiating sound reimbursement rates and contracts with other providers, and assessing the financial impact of changing service mixes. A marketing strategy was used to enhance the ability of the centers to provide a comprehensive package of services. Collaboration with the area agency on aging and other community organizations and volunteers in the aging network was found to help establish referral networks and subsequently increase the number of elderly patients served. Finally, development of special services for the elderly, such as adult day care, case management, and health education, was found to increase program visibility, opportunities to work with the network of services for the aging, and clinical utilization.

the year 2030 they are expected to account for 21 percent (4). As this change in population occurs, the demand will also rise for health care services, including nursing home, hospital, and community health programs (5). The Department of Health and Human Services' Administration on Aging recognized the current and projected trends and in 1986 responded by entering into a formal memorandum of agreement with the Department's Public Health Service to collaborate in the delivery of health programs for older Americans. In addition, supplemental funding was channeled to those community health centers which proposed to develop or expand geriatric health care programs (1).

It is less clear how and under what circumstances a comprehensive geriatric program can be financed adequately to provide the wide variety of services

needed (6). C/MHC funding is usually deficient in a variety of health services important to older patients—dental care, including reconstructive dentistry and dentures, and physical therapy, including professional gait training, cardiovascular training, and in-home physical therapy. Mental health services have been cited as frequently necessary, but inadequately reimbursed. Health education has been viewed as one of the most important services in terms of maintaining elderly clients in the community; yet there is a serious lack of reimbursement for this preventive service.

The Bureau of Health Care Delivery and Assistance (BHCDA) of the Health Resources and Services Administration of the Public Health Service contracted with La Jolla Management Corporation and Duke University Center on Aging to identify the successful components of C/MHC programs. This paper is a review of the findings from that portion of the study related to the financing of geriatric programs (7). We will describe the methods used for evaluating the C/MHC geriatric programs and the resulting findings and recommendations.

Methods

Five data sources were used for this study of C/MHCs. A technical advisory committee of national experts in gerontology was established to provide guidance to the study team. The 11-member committee included Federal experts, non-Federal representatives of the geriatric care community, C/MHC representatives, and consumers of geriatric health care services with elderly advocacy experience. An all-day meeting was held early in the project to discuss the purpose and methodology of the study, site selection, interview instruments, and final report. Committee members were consulted informally throughout the project and formally for guidance after the completion of the first two case studies, at midpoint of the study, and prior to developing the final report.

Case studies were conducted of 10 C/MHCs with good geriatric programs. General information on financing and use were obtained from both BHCDA's computerized information system (BHC-DANET) and the Bureau Common Reporting Requirements (BCRR) for each site. Additional program data were obtained from the Public Health Service Regional Offices and from the health centers directly. The case studies included site visits, interviews of key project personnel (clinical and administrative), and client-specific information

from the health centers' records. Case studies focused on planning methodologies used by health centers, the scope of geriatric services offered, content of geriatric health care plans, staff training, extent of collaboration with other community agencies, marketing, and financing.

The 10 health centers in Los Angeles, Baltimore, Accomac, VA, Tucson, Hayneville, AL, Portland, OR, 2 in Seattle, Murphysboro, IL, and Kansas City, MO, were selected from a list of 35 potential "good practice" sites identified by PHS Central and Regional Office staff members and review of BCRR data.

Criteria used for selecting the 10 sites included (a) length of operation of the geriatric program (those selected had been in operation for approximately 5 or more years), (b) demographics associated with the C/MHCs, such as the growth in use by the 65 and older cohort during the previous 3 years and whether a center was urban, rural, or migrant or a combination, (c) number of current elderly served as a percentage of total users, (d) innovativeness of the program design, including liaisons with community agencies and organizations and use of an interdisciplinary team approach to service delivery, (e) use of case management, and (f) level of funding from sources other than the Federal Government. A brief review of the 10 sites is displayed in the table. Data from the selected sites were collected in 1987.

After site selection, a general protocol was developed for examining pre-site, on-site, and post-site activities. Pre-site testing secured specific data and information, including each center's strategic plan for positioning itself in the health care market place, its geriatric health care plan, organizational chart, provider profile, admitting privileges, chart of accounts, networking agreements, service area map, quarterly or annual reports, trend data regarding use, program costs, and revenues.

Interviews were scheduled with the center's project director, chief financial officer or business manager, medical director, aging service coordinator, at least one board member, and representatives of the aging network in the community. Individual patients were not interviewed, because conducting a consumer survey was beyond the scope of the study.

During the visits, approximately eight interviews were conducted per site. Clinic ambience and patient flow were observed, and additional administrative data were provided. Additional satellite sites were visited, if appropriate and where possible. At the conclusion of the visit, the study team

Community and migrant health centers selected for case studies of geriatric programs, 1987

<i>Health center and location</i>	<i>Urban, rural, or migrant</i>	<i>Total users of medical services 1986</i>	<i>Total users of medical services, 65 and older 1986</i>	<i>Program highlights</i>
AltaMed Health Service Corporation, Los Angeles, CA	Urban	4,639	291	Adult day health care center, Medicaid 2176 waiver services
Baltimore Medical System, Inc., Baltimore, MD	Urban	13,067	6,030	Medicare waiver, home health, hearing impaired services
Eastern Shore Health System, Inc., Accomac, VA	Rural, migrant	9,166	1,649	Health education program, community outreach worker
El Rio Santa Cruz Neighborhood Center, Inc., Tucson, AZ	Urban	13,997	2,416	Medicare's all-inclusive flat rate reimbursement, home health
Lowndes County Health Services Association, Hayneville, AL	Rural	1,935	184	Day health program, retired senior volunteer program
Multnomah County Dept. of Human Services, Portland, OR	Urban	39,495	845	Primary preventive dental service, block nurse program
Pike Market Community Clinic, Seattle, WA	Urban	3,276	914	Geriatric psychiatric and mental health groups, home health
SeaMar Community Health Center, Seattle, WA	Urban, migrant	9,490	314	Home health, home chore
Shawnee Health Service and Development Corporation, Murphysboro, IL	Rural, migrant	6,681	640	Case coordination, health and education in senior centers
Wayne Miner Health Center, Inc., Kansas City, MO	Urban	11,177	1,138	High blood pressure project, adult day care center

SOURCE: Reference 7.

debriefed the center director and senior staff members to elicit any missing information and to discuss perceived problems, possible solutions, and any particularly innovative mechanisms of service delivery.

Post-site visit activities included assessing field notes and conducting followup telephone discussions to obtain missing information. A full report was drafted and sent to each site, technical advisory committee members, and BHCDA personnel for review and comments. After incorporating suggested revisions, the final reports were provided to BHCDA.

Financing a Geriatric Program

The 10 C/MHCs used several traditional as well as innovative techniques for financing their geriatric programs. Their successes were frequently the result of an entrepreneurial spirit and the willingness to break new ground and take risks. The most effective techniques used for financing their geriatric programs included tapping existing sources of funding, using cost-per-user information, developing and marketing a package of services, increasing user incentives, reducing barriers, collaborating with the area agency on aging and other commu-

nity organizations and volunteers, and developing special services for the elderly.

Existing funding sources for C/MHC geriatric services. Funding sources included sections 329 and 330 of the Public Health Act, third party reimbursement, State and local sources, foundation and corporation grants and donations, and patient fees. The primary source of funding for the C/MHCs came from sections 329 and 330 grants. These grants reimbursed C/MHCs for primary health care services as well as for preventive services which were often nonreimbursable from other funding sources. Reimbursable services included, for example, hypertension screening, cholesterol checks and other clinical tests, immunizations, and treatment for conditions such as hypertension, heart disease, diabetes, arthritis and degenerative joint disease, cancer, chronic obstructive pulmonary disease, and urinary incontinence. The awarding of section 329 and 330 grants was based largely on the number of patients served or potential patients in the C/MHC's catchment area. It was important, therefore, that the C/MHC serve a relatively large patient population to assure continued funding.

Third party reimbursement came from the Medicare and Medicaid Programs, medigap policies, and private insurance. A portion of the cost of many traditional clinical services, including both hospital and physician services, came from Medicare. Medigap policies provided reimbursement for that portion of the service that Medicare did not cover. Some C/MHCs also used Medicare to reimburse home health services.

The Sea Mar Community Health Center in Seattle operated a Medicare-certified home health agency providing nursing, home health assistance, mental health services, physical therapy, speech therapy, and occupational therapy. The Baltimore Medical Systems Center obtained a Medicare waiver developed under the Robert Wood Johnson Municipal Health Services Program which allowed for cost-based reimbursement for comprehensive ambulatory care services and services which were not traditionally covered by Medicare such as optometry, dental, and transportation.

Medicaid was established in 1965 to reimburse health care providers for traditional health care services to low-income clients. In 1981, the Omnibus Reconciliation Act expanded Medicaid by allowing service providers in approved areas also to be reimbursed for home and community-based services. The goal of this home and community-based care program was to target services to frail elderly and severely disabled people living in the community, as a means of preventing or delaying nursing home admissions. Reimbursable services included homemaker, home health assistance, personal care, case management, adult day care health, and respite services.

The C/MHCs were a natural provider of such services for the elderly. The benefits to the C/MHC of becoming a contract provider were not only obtaining Medicaid reimbursement for the services provided, but also attracting the typically hard to reach frail elderly, and improving the financing of a full range of geriatric care services. The Lowndes County Health Services Center in Hayneville, AL, was particularly successful at using these funds. Its initial assessment of clients, monthly review of services, reassessments of case management services, weekly checkups for those in day care, health counseling, medication review, and referrals, homemaker services, respite care, and transportation were all Medicaid-funded.

State and local funding was obtained to provide a variety of health related services which typically strengthened C/MHC comprehensive geriatric programs. The local area agencies on aging provided

funds to some C/MHCs for a variety of services, such as community outreach, home health aid, health education, nutrition, adult day health, transportation to and from health clinics, mental health services, hospice, and respite for caregivers. The Eastern Shore Rural Health Center in Accomac, VA, received funding for a community outreach worker who provided transportation to elderly patients, scheduled appointments for them, and helped them obtain other community services such as food stamps, an energy fund, Supplemental Security Income, and Meals on Wheels. The Shawnee Health Service Center in Murphysboro, IL, received support from an area agency for a nursing home ombudsman and from the Illinois Department of Aging for elder abuse, companion care, and home health projects.

State and local departments of transportation were another source of funding, with some departments supporting transportation of patients to and from the C/MHC. Community mental health departments reimbursed some of the C/MHCs for services to elderly patients. Other State and local funding came from health departments. The Eastern Shore Rural Health Center collaborated with the local health district on a special grant for the expansion of home health services.

The U. S. Department of Housing and Urban Development also provided funding; for example, the Lowndes County Health Services Center received approval for a 60-unit housing development for the elderly. State supported universities likewise provided funds and sponsored a variety of services and programs for the elderly, as well as educational workshops and seminars for clinicians and administrators. One such collaboration occurred at the Multnomah County Health Center in Portland, OR, which operated a joint program with the Oregon Health Sciences University, Department of Community Dentistry, designed to improve dental and medical health of elderly patients.

Foundations, other private organizations, and individuals were also important sources of funding for C/MHC health care services. The Shawnee Health Service Center received funding from the Southern Illinois Dental Society to provide dental services for the elderly. The Multnomah County Health Center received support from the Northwest Area Foundation to operate the Block Nurse Program which funded five registered nurses who provided home visits for elderly patients living on fixed incomes. Other examples include the Eastern Shore Rural Health Center which received substantial support from the Tidewater Dementia Center

and a local church, the Baltimore Medical Systems Center which received funding from the Robert Wood Johnson Foundation, the El Rio Center in Tucson which obtained funds by creating an employee contribution program, and the Pike Market Community Center in Seattle which obtained funds by prominently displaying in its reception area a large fishbowl for donations. Other funding sources included the Kellogg Foundation, health maintenance organizations, United Way, American Association of Retired Persons, American Heart Association, and the American Cancer Society.

Using cost-per-user information. Administrators from several C/MHCs reported that their geriatric programs benefitted from using cost-per-user information to monitor service use patterns and track actual costs of serving geriatric patients. Trend analysis of these data allowed for assessment of the marketing and financial impact of changing service mixes and helped to identify those service mixes that strengthened the financial viability of the programs as well as those which had negative impacts. Cost-per-user information was also reported to highlight those services which were most appropriate as a "drawing card," that is, discounted or free services offered to attract elderly clients and subsequently encourage them to use C/MHC reimbursable medical services more fully. Finally, cost-per-user information enhanced the C/MHC's ability to negotiate sound reimbursement rates and contracts with other providers or payers such as health maintenance organizations and prepaid Medicaid plans. This enabled the health center to avoid offering a service for less than it cost to provide and to avoid paying more for a service than was necessary.

Developing and marketing a package of health services. Some C/MHCs provided geriatric health services which were money losers for the center because there were no sources of funding to reimburse the costs incurred, or reimbursement was insufficient to cover costs. Limited funds under sections 329 and 330 resulted in a lack of financial support for a variety of services deemed essential to a comprehensive geriatric program. Frequently reported funding deficiencies included dental care such as reconstructive dentistry and dentures, and physical therapy, including professional gait training, cardiovascular training, and in-home physical therapy services. Likewise, while Medicare was a primary funding source for clinical services, the cost sharing provisions and limited benefits under Medicare resulted in many services, deemed essen-

tial for a comprehensive geriatric program, going unsupported.

For example, two C/MHCs indicated that funding for medications was critically short, and two cited inadequate or no funding for transportation. Other services which typically lacked funding included mental health services, podiatry, and telephone consultations necessary for maintaining continuity of care. The Altamed Health Service Center in Los Angeles found that physician home visits for bedridden patients with problems such as bedsores and senile dementia were insufficiently reimbursed. Such visits took extensive amounts of time both on-site and in coordinating followup care by registered nurses.

The 10 C/MHCs studied relied on multiple funding sources to develop comprehensive packages of geriatric services. They offered a diversity of services, almost all of which were believed to be financially self-supporting and which increased the number of patients seen. Medicaid's home and community-based care program enabled centers to provide services which increased the patient load and resulted in more traditional services being used, such as those supported under sections 329 and 330 as well as Medicare and Medicaid.

At the Central Seattle Community Health Center a hypertension monitoring program was developed and funded by local private foundations. This resulted in increased numbers of clinic users and allowed for updated hypertension protocols and improved tracking of hypertensives. At the Shawnee Health Service Center, a demonstration project was funded by the Illinois Department on Aging which allowed the center to serve patients who were eligible for Medicare in-home services but whose needs were greater than the number of home health visits reimbursed by Medicare. In developing the service packages, several centers found technical assistance to be effective for maximizing third-party reimbursement, particularly from Medicare and Medicaid. The manner in which services were described on a patient's bill, for example, significantly impacted reimbursement levels.

A review of the centers' procedures found that developing a comprehensive package of services typically began with a needs assessment to learn which services elderly persons in the community desired and needed and which services were currently available. It was clear from the C/MHC case studies that elderly persons should not be told what will be done for them, but rather, should be asked which services they would like to have. This information was obtained from need and desire

assessments, community surveys, public hearings, area agencies on aging, and elderly focus groups. Surveying the directors of senior centers was reported to be an excellent starting point. These people were found to have a wealth of knowledge about the needs and wants of the elderly, as well as effective approaches to working with them.

Administrators from several centers reported that an effective marketing plan should address at least two areas—public relations and fund-raising. Public relations was described as getting the word out about the program to the elderly population which, in many cases, had never been singularly targeted for specific services by the health center. Public relations strategies included making presentations to persons in high-rise elderly apartments and church meal programs, making presentations to and collaborating with community agencies and organizations (especially area agency on aging programs), meeting with hospital discharge planners, and encouraging patients to “spread the word” about the program.

Program staff members of the Eastern Shore Rural Health Center reported that approximately one day per week in staff time was spent in such public relations marketing activities as the development of program brochures, welcome letters to new users, educational literature, and a community service directory. Several of those interviewed stressed the importance of simultaneously addressing future financial assistance and fund-raising. Collaboration among staff and board members yielded information regarding potential contacts among local foundations, corporate contributors, community groups, and churches to support the geriatric program.

The in-home program of the Wayne Miner Health Center in Kansas City was marketed by letters to physicians, to the elderly, and to apartment hotels and community churches, and by public service announcements on television and radio to the general public. The director of the program also marketed it through one-on-one contacts with local physicians and social service providers. Wayne Miner Health Center staff members visited libraries to provide home care literature, attended chapter meetings of AARP, and made presentations at neighborhood meetings.

In a second example, the Multnomah Center staff members marketed services by maintaining contacts at senior high-rise buildings and with case managers of Medicaid’s home and community-based care program, writing articles for the CHC newsletter and local neighborhood newsletters, dis-

tributing posters, contacting businesses, churches, and other organizations, providing health lectures, and involving volunteers on a one-to-one basis with seniors. A third example was found at the Central Seattle Community Health Center where a good relationship was developed with the local press which used the center as a focus for human interest stories and involved center staff members in a television panel discussing downtown housing problems.

Increasing user incentives and reducing barriers. Persons interviewed identified four major factors that served either to encourage or discourage the use of geriatric services at C/MHCs. These included the center’s image, availability of social services, clinical issues, and financing. Factors affecting a positive image of the geriatric program included the clinic’s convenience to public transportation routes and parking facilities, atmosphere, socialization (availability of day health and day care programs), easy physical access (ramps, handrails), satellite sites, bicultural and bilingual staff capabilities, and a positive “community clinic” image as opposed to a “welfare image.” Factors reported to cause a negative image and a subsequent barrier to service use included clinic location, crowded waiting rooms, scheduling problems, and poor community relations.

To overcome a negative image, there were a variety of methods used. For example, several persons noted that a welfare image was overcome by relocating or remodeling the center. Scheduling problems were resolved by using special blocks of time for the appointments of elderly patients to accommodate their preferences and by juggling the existing schedule to squeeze in unexpected appointments.

A second factor, availability of social services, was reported to act as an incentive by providing those services that were particularly desirable to older persons, such as meals and free health education. The Lowndes County Health Services Center offered a meals program which attracted patients by operating the “Grocery Initiative”—a program which awarded nutritional groceries to participants based on the number of days they attended the meals program during the month. Twenty or more days of attendance resulted in an award of \$30 worth of groceries, and 8-11 days of attendance resulted in \$10 worth. The most significant barrier to social services was lack of transportation. Methods for addressing this barrier included buying vans, sharing vans with an area agency on aging, and negotiating a rate with a transportation service.

Clinical issues were a third set of factors reported to act as incentives or barriers to service use. These centered around service availability, clinical procedures, and staff. Clinical incentives included on-site therapy, other ancillary services, podiatry, continuity of care, and a highly qualified clinical staff. Major barriers included a lack of staff training, continuity of care, and physician turnover.

Clinical barriers were reported to be particularly difficult to solve. Physician turnover was influenced by a variety of factors such as insufficient salaries, lack of spouse employment opportunities, lack of desirable schools, lack of cultural opportunities, management policies unacceptable to the physician, and ineffective recruitment and retention procedures and techniques. Overcoming high rates of physician turnover was addressed by assessing the specifics of the problem and attempting to improve conditions to the extent possible.

The Lowndes County Health Services Center, for example, was located in an impoverished area where racial tensions had historic roots and there were few amenities. These factors made it very difficult to overcome staff turnover since the center could not produce things such as desirable schools and museums. As a solution, center management emphasized the great need for health services in the center's catchment area and highlighted the human suffering being reduced by the center staff's assistance.

Many of those interviewed noted that continuity of care was a major clinical issue that acted either as an effective incentive or a barrier to use of center services. It was noted repeatedly that older people have multiple medical and support service needs involving multiple providers. Management of multiple chronic disease and disability required intensive coordination of medications, disease and disability interventions, and restorative therapies over long periods. Continuity of care was necessary to assure high quality health care and patient confidence in the center.

Six of the ten centers used an individual staff person to serve as aging services coordinator to enhance continuity of care. Of these six persons, two were registered nurses, while the others included an internist, the associate health center director, the health center assistant director, and a Retired Senior Volunteer Program director. The Baltimore Medical Systems Center encouraged continuity by providing bonuses to physicians who demonstrated continuity of service to their hospitalized patient. Even with staff service coordinators and incentives, overcoming problems associated

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with continuity of care was reported to be difficult. Coordination was particularly difficult when several physicians treated the same patient. In some of these cases, the patient did not understand what was happening and subsequently began to feel that no single physician was caring for him or her. To overcome this problem, an attempt was made to explain to the elderly patient or caregiver the reasons for the referrals being made.

Issues of financing that were reported to act as incentives focused primarily on ways of reducing a patient's anxiety about paying for services. Such incentives included offering a sliding fee scale and payment schedules in line with the patient's ability to pay. Similarly, the reported barriers caused by financing were most often related to the patient's inability to pay. For example, the patient may have wanted or needed a service that was not reimbursed by third parties, or the patient may have lacked the ability to pay Medicare deductibles and co-payments.

Methods used to minimize this barrier included educating the general public, government officials, and legislators of the shortcomings of existing health financing mechanisms for the elderly. Concerns about the stringency of eligibility criteria for certain Medicare policies were presented to legislators with recommended revisions. State primary care associations were reported to be excellent vehicles for educating the general public and legislators about these problems. While education efforts were found to be effective, the results were reported to be slow in coming. Several of those interviewed noted the importance of soliciting churches and philanthropic organizations for solutions to financing problems on a short term basis.

Collaborating with the area agency on aging, other community organizations, and volunteers in the ag-

ing network. Increased collaboration with the area agency on aging and other community organizations that served the elderly, such as hospitals, health departments, and social service departments was reported to help in establishing referral networks, increasing the number of elderly patients served, and identifying potential funding sources. Collaborating with transportation providers was reported to be particularly effective at increasing the number of elderly patients by offering better access for the elderly who wanted to use the clinic's geriatric program. The Eastern Shore Rural Health Center collaborated with the county's regional comprehensive mental health center under an agreement whereby the mental health center's van picked up and delivered medical patients to the CHC two days per week. Likewise, the Lowndes County Health Services Center reported a collaborative relationship with a rural transportation agency that made trips throughout about half of the center's service area.

Human service organizations concerned with the needs of the low-income elderly were also reported to be particularly effective collaborators, since primary care was one of their concerns. A contract between the Wayne Miner Health Center and the Department of Social Services, Division of Aging, for example, provided resources to the center for the delivery of personal care and homemaker services under the Social Service Block Grant program.

Collaborative relationships in programs for the elderly were reported to be similar to developing such relationships for the C/MHC in general. Health center administrators and their staffs had particular expertise in this activity. Services for the elderly, however, required linkages with organizations with which C/MHC staff members had not worked. Therefore, developing successful linkages was dependent upon a conscious effort among administrative, clinical and support staff members as well as board members.

A pre-condition to establishing collaborative relationships was the commitment of the C/MHC staff, management, and the board of directors. Achieving this commitment required a training session for all three groups to facilitate their understanding of the needs of the elderly and current and potential services. Typically, early in this process, the C/MHC staff were asked to identify community organizations which offered potential referrals and funding and to discuss ways in which collaboration could be developed or strengthened. This activity enhanced collaboration

efforts as well as provided C/MHC staff members with a clear understanding of the future directions of the center.

There were a variety of activities reported to strengthen the relationship between the C/MHC geriatric program and community organizations. Community leaders in the network of services for the aging were solicited to serve on the board of the C/MHC. Likewise, members of the C/MHC participated in advisory councils or committees of organizations in the aging network. In some cases, the C/MHC geriatric services and the aging network services were provided at a mutually agreed upon location, which allowed for a "one-stop shopping approach." Finally, center staff members actively sought invitations to the aging network's meetings concerning information and referral and case management to enable the network to gain a clear understanding of what the C/MHC geriatric program offered.

Collaboration with volunteers in the community, particularly elderly volunteers, was reported to be another valuable source of referrals, as well as a means of reducing operating costs and helping older persons feel ownership in the geriatric program. Examples of specific activities in which elderly volunteers assisted included involving retired registered nurses and licensed practical nurses in home health, home chore, and homemaker services, and conducting blood pressure clinics at convenient locations in the community. Older volunteers were recruited to staff other services and were solicited to write articles for a geriatric program newsletter and C/MHC newsletter.

A strong volunteer component was a highlight of the Altamed Health Service Center. Older volunteers were recruited to provide peer counseling, friendly visiting, and support to caregivers of the elderly. The Lowndes County Health Services Center was a second C/MHC highlighting the Retired Senior Volunteer Program.

Developing special service programs for the elderly.

There were 20 special service programs for the elderly among the 10 centers studied. Developing special service programs, such as adult day care, case management, or health education, was reported to increase greatly the visibility of the geriatric program within the community, increase the opportunity to work with the aging network, and increase use of the clinic.

Several C/MHCs found that offering adult day health and day care provided the geriatric program an opportunity to come in contact with older

persons who were often Medicare and Medicaid eligible. These were financially attractive patients who were likely to use additional C/MHC services. Center program staff members noted that it was crucial that a strong commitment be obtained from the State Medicaid agency, since this was a primary funding source. C/MHC staff members reported that the need for adult day health and day care was large in comparison to the willingness of State agencies to fund the services.

At the Lowndes County Health Services Center, an adult day health and day care program, funded through Medicaid, had an enrolled patient population of about 40 with average attendance of 20 per day. Although the need for the program could have supported a much higher enrollment, the State had capped enrollment. There were also physical space limitations and facility accessibility constraints which prevented any significant growth. The case manager of the program attributed the program's success to clients receiving quick referrals if their condition warranted, clients receiving free catered meals, crafts, and help with picking up medications at the drug store.

In many States, there were funds available through Medicaid's Home and Community-Based Care Program to provide special services such as case management, home health aid, adult day health, homemaker, personal care, habilitation, and respite services. In order to be eligible for these services, persons had to be 60 or older, Medicaid eligible, demonstrate that they were at high risk of institutionalization, and meet any other special requirements of their State's program. Reported advantages of the home and community-based programs included bringing the C/MHC in contact with potential clients, increasing the geriatric referral network, and providing a needed community service.

The Shawnee Health Service Center offers a good example of the provision of case management. Its program provided comprehensive assessments and care plans for in-home and community based services for people 60 and older. Center staff members performed nursing home pre-screenings and provided authorization of those services that would maintain the client in the home setting as opposed to the nursing home. The case managers were responsible for monitoring the care plan and for changing the plan as the older person's needs changed. The case management program was funded through Medicaid's home and community-based care program and was part of a consortium

of four CHCs which served approximately 2,200 clients in 1986, with expenditures of approximately \$466,000.

A final special program to be discussed is health education which was reported to have increased visibility of the geriatric programs, increased the opportunity to work with the aging network, and increased clinic use. Typically, there was no third party reimbursement for this service. Therefore, reimbursement was either on a self-pay basis, supported by grants, or offered as a public service program by the C/MHC geriatric program.

Health education was one of the core services for the elderly at the Eastern Shore Rural Health Center where 700 persons were served within four senior centers. The program coordinator researched, planned, and implemented a health education program monthly. Extensive program planning time was necessary, since purchased health education materials were often inappropriate for the elderly persons involved (85 percent were below the poverty level). At the health education sessions, the program coordinator recorded blood pressure, checked medications, provided counseling on weight, diet, and diabetes. In 1986 the program was funded by Department of Health and Human Services supplemental funds of approximately \$62,000 and served 1,649 elderly patients.

References.....

1. Ginzberg, E., and Ostow, M.: The community health care center: current status and future directions. *J Health Polit* 10: 283-297 (1985).
2. Doty, P., Liu, K., and Wiener, J.: An overview of long-term care. *Health Care Fin Rev* 6: 69-78 (1985).
3. Yeo, G., Skurnick, J., and Crapo, L.: Effects of a geriatric clinic on the functional health and well being of elders. *J Gerontol* 42: 252-258 (1987).
4. Spencer, G.: Projections of the population of the United States, by age, sex, and race: 1983 to 2080. *Current Population Reports Series P-25, No. 952* (1984).
5. U.S. Senate Special Committee on Aging in conjunction with the American Association of Retired Persons, the Federal Council on the Aging, and the U.S. Administration on Aging, U.S. Department of Health and Human Services: *Aging America: trends and projections, 1987-88 edition*. Washington DC, 1988.
6. Parlak, B., and Higgins, R.: The partnership potential: community health centers and area agencies on aging. *Aging* 357: 10-13 (1988).
7. Assessment of the current utilization of community/migrant health centers by the elderly and an assessment of the capability of health centers to develop comprehensive community-based primary care health service systems for the elderly. La Jolla Management Corporation, Columbia, MD, July 1987.